

The Interface



DEMORALIZATION IN PATIENTS WITH MEDICAL ILLNESS

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This ongoing column is dedicated to the challenging clinical interface between psychiatry and primary care—two fields that are inexorably linked.

ABSTRACT

Demoralization is a dysphoric state encountered in both psychiatric and medical populations, and is characterized by the individual's sense of disempowerment and futility. While depression may coexist with demoralization, they appear to be distinct clinical entities, with the former being characterized by anhedonia and the latter being

characterized by helplessness. Assessment measures for demoralization are available, such as the Diagnostic Criteria for Psychosomatic Research and the Demoralization Scale of the Minnesota Multiphasic Personality Inventory version 2 restructured clinical scales. However, the administration requirements of these measures tend to limit them to

research environments. As for prevalence, demoralization is commonplace in medical populations, perhaps even normative. However, up to one-third of physically ill patients experience *clinically* meaningful demoralization. Identification by the clinician is important as there are several proposed interventions that may be helpful in alleviating demoralization in medically compromised patients.

KEY WORDS

Demoralization, medical illness, psychosomatic, dysphoria

INTRODUCTION

According to the Merriam-Webster online dictionary, *morale* is defined as the level of an individual's psychological well being based on such factors as a sense of purpose and confidence in the future.¹ In turn, *demoralization* is defined in the Encarta World English Dictionary as the erosion or destruction of courage, confidence, or hope of a person or group.² In other words, demoralization entails the loss of a specific psychological essence by the individual, an essence that is not necessarily encompassed in the diagnostic construct of depression.

Why is the denotation between demoralization and depression salient? A number of investigators have expressed the concern that the common distress syndromes experienced by medically ill individuals fall outside of the classic descriptions of the mood and anxiety disorders that are presented in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*.^{3–5} In an effort to improve descriptive classification and clinical identification, researchers are beginning to define these distress syndromes, and demoralization is emerging as a clinically relevant

entity among medical patients. In this article, we review the concept, clinical features, assessment, prevalence rates, and treatment of demoralization in medical populations.

THE CONCEPT OF DEMORALIZATION

According to Clarke et al,⁶ the concept of demoralization was originally proposed by Jerome Frank, who described such patients as impotent, isolated, despairing, alienated, rejected, and with low self esteem.⁷ However, in broaching this novel concept in 1974, Frank was referring to demoralization in the context of the psychotherapy treatment of psychiatric patients—specifically, that it was important for the therapist to combat patient demoralization in any type of psychotherapy endeavor.⁷ In contrast, for the remainder of this article, we are referring to demoralization as an insidious psychological distress syndrome among medically ill individuals.

From a conceptual level, demoralization in medical patients seems to extend beyond the standard meaning provided by dictionary resources. Among medical patients, demoralization appears to harbor the fundamental psychological elements of disempowerment (e.g., the inability to function at one's previous level) and a sense of futility (i.e., the sense that the medical situation and its functional ramifications are never going to improve).

Given the potential psychosocial and physical limitations imposed by numerous medical maladies, physical illnesses are by their very nature demoralizing. Therefore, some degree of reactive demoralization might be normative or expected,⁸ which suggests a dimensional nature to these symptoms, from normal to impairing.

TABLE 1. Proposed psychological features of demoralization

Author	Year of Publication	Description
D'Arcy ⁹	1982	anxiety, sadness, helplessness, hopelessness, lack of self-esteem
de Figueiredo ¹⁰	1993	distress, subjective incompetence
Kissane et al ¹¹	2001	hopelessness, loss of meaning, existential distress
Clarke et al ¹²	2003	anxiety, apprehension, inability to cope, loss of confidence, helplessness, hopelessness
Griffith et al ¹³	2005	despair, helplessness, sense of isolation
Clarke et al ¹⁴	2006	inability to cope, helplessness, hopelessness, diminished personal esteem

CLINICAL FEATURES OF DEMORALIZATION

A number of authors have proffered clinical descriptions to characterize the psychological elements of demoralization in medical patients.^{9–14} Some examples of these descriptions are presented in Table 1. Note that while the affective texture of demoralization entails dysphoria, the preceding authors ubiquitously describe feelings of helplessness and hopelessness.

Note that many of the descriptors in Table 1 invite the diagnostic consideration of depression. However, according to the literature, there are distinct differences between demoralization and mood disorders. To clarify, de Figueiredo emphasizes that demoralization is characterized by feelings of subjective incompetence and helplessness, whereas depression is characterized by anhedonia or a lack of pleasure in experiences.¹⁰ In addition, Clarke and Kissane explain that hedonic

capacity is preserved in the demoralized, but not in the depressed.³ There may be other differences as well. For example, through empirical investigation, Clarke et al¹² found that demoralization was associated with avoidance coping, whereas anhedonic depression was associated with fewer social activities and close relationships. These impressions and data underscore that demoralization, while associated with dysphoria, is not equivalent to any form of *DSM* depression.

ASSESSMENT OF DEMORALIZATION

The diagnostic criteria for psychosomatic research. In an effort to more adequately address the psychological distress that is encountered in patients with somatic ailments (i.e., psychological states that seem to fall outside of the diagnostic range of the *DSM*), an international consortium of investigators developed the Diagnostic Criteria for

TABLE 2. Psychosomatic Syndromes Identified by the Diagnostic Criteria for Psychosomatic Research (DCPR)¹⁵

Alexithymia (i.e., a deficiency in understanding, processing, or describing emotions)
Type A behavior
Irritable mood
Demoralization
Disease phobia
Thanatophobia (i.e., an abnormal and excessive fear of death)
Health anxiety
Illness denial
Functional somatic symptoms secondary to a psychiatric disorder
Persistent somatization
Conversion symptoms
Anniversary reactions

Psychosomatic Research (DCPR) in 1995.¹⁵ The DCPR is a structured interview that consists of 58 questions with yes/no response options. The DCPR identifies 12 syndromes (Table 2). This measure appears to have excellent interrater reliability, with kappa values for the individual syndromes ranging from 0.69 to 0.97 (for demoralization, the kappa value was 0.90).¹⁶ According to Grassi et al,¹⁷ the overlap between diagnoses confirmed by the DCPR and *DSM* is low (e.g., 58% of patients with a DCPR diagnosis did not have a *DSM* diagnosis), suggesting that the DCPR is genuinely capturing clinical phenomena outside of the range of *DSM* disorders.

According to the current version of the DCPR, the diagnosis of demoralization entails the following criteria: 1) the presence of a feeling state characterized by the patient's

awareness of having failed to meet his or her own expectations (or those of others) or being unable to cope with some pressing problems; as a result, the patient experiences feelings of helplessness, hopelessness, or giving up; 2) the feeling state is prolonged, generalized, and present for at least one month; and 3) the feeling is closely antedated by the manifestations of a medical disorder or exacerbate its symptoms.⁵

The Demoralization Scale of the Restructured Clinical Scales of the MMPI-2. The Minnesota Multiphasic Personality Inventory, version 2 (MMPI-2), contains restructured clinical scales, which were developed to sort out valid somatic symptoms from other psychological phenomena, such as depression.¹⁸ The items that constitute these scales occur after item 370 in the MMPI-2 booklet. One such scale, the demoralization scale, provides an appraisal of a respondent's current overall sense of well being, whether expressing satisfaction with life or dissatisfaction or despair. In one study, the demoralization scale was found to be a good predictor of rehabilitation outcome.¹⁹ The MMPI-2 is typically administered by a psychologist, and there is a fee for administration and interpretation.

PREVALENCE OF DEMORALIZATION

Several studies have examined the prevalence of demoralization in clinical populations, all using the DCPR. The prevalence rate of demoralization in endocrine patients was 34 percent (50/146); 39 percent (85/219) in inpatients referred to a consultation/liaison service; 30.4 percent (245/807) in consecutive medical outpatients; 28.8 percent (42/146) among patients with cancer; and 33 percent (33/100) in medical

patients with a *DSM* diagnosis of adjustment disorder.²³ These findings indicate that about one-third of various type of medical patients suffers from demoralization.

TREATMENT OF DEMORALIZATION

While a robust discussion of the treatment of demoralization is beyond the scope of this article, several authors offer brief overviews. In this regard, Griffith et al¹³ discuss the importance of teasing out relevant existential themes and then tailoring interventions to address these themes. Kissane et al¹¹ suggest continuity of care, active symptom management, exploration of attitudes toward hope and meaning in life, the balancing of support for grief with hope, searching for a renewed purpose and role in life, cognitive restructuring of negative beliefs, spiritual/religious support, promotion of relatedness with others, and enhancement of family functioning. Sirri et al⁴ highlight the importance of regular, supportive, empathetic contact with healthcare providers as well as cognitive-behavioral techniques.

CONCLUSIONS

Demoralization is a commonplace clinical phenomenon among medical patients and seems to escape adequate address by the *DSM*. Characterized by dysphoria, but distinct from depression, demoralization is psychologically founded on disempowerment and futility. This syndrome seems to affect about one-third of all medical patients. While formal assessments are available, such as the DCPR and the MMPI-2 restructured clinical scales, these measures remain somewhat impractical for use in clinical settings due to their format of administration. However, we advise clinicians to be alert to medically related dysphoria, attempt

to identify underlying demoralization, and, if present, address it in the medical setting. Clearly, demoralization among patients is a clinical concern that bridges the psychiatric/primary-care interface.

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